PATIENT REGISTRATION

PERSONAL INFORMATION

Name (*last, first, middle, nickname*) ______________________________ **Date of Birth**__________

Marital Status (*circle one*) Married Single Widowed Child Social Security Number__________________

Address______________________________City______________State__________Zip___________

Telephone (*home*) ____________ (*cell*) ____________ (*work*) ___________Email______________________

Occupation______________________________ Employer Name______________________________

Employer Address______________________________City______________State__________Zip___________

Whom may we thank for referring you to our office? ______________________________

Reason for today's visit______________________________

Are you interested in cosmetic dentistry/whitening? ______________________________

Do you like your smile? **Yes** **No** If *no*, what would you change? ______________________________

PERSON RESPONSIBLE FOR ACCOUNT (*If different from patient information*)

Name______________________________Date of Birth__________

Relationship to Patient______________________________ Social Security Number______________________________

Address______________________________City______________State__________Zip___________

Occupation______________________________ Employer Name______________________________

Employer Address______________________________City______________State__________Zip___________

INSURANCE INFORMATION

Insurance Company______________________________Phone____________________

Name of Group Dental Program______________________________Policy Number____________________

EMERGENCY CONTACT

Name______________________________Phone Number (daytime) ____________

Address______________________________City______________State__________Zip___________

MEDICAL INFORMATION

Name of Family Physician______________________________Date of Last Physical Examination____________

Are you presently under the care of a physician? **Yes** **No**

Women: Are you pregnant at this time? **Yes** **No**

Women: Are you nursing at this time? **Yes** **No**

Have you ever been told you have sleep apnea? **Yes** **No**

Have you had a joint replacement in the past 2 years? **Yes** **No**

Have you ever had an adverse reaction to a dental injection? **Yes** **No**

Do you snore? **Yes** **No**

Have you ever been told you needed to take a pre-med? **Yes** **No**

Do your jaws ever click or pop? **Yes** **No**

SIGNATURE______________________________ **TODAY'S DATE**____________________

MEDICAL INFORMATION *(circle either YES or NO)*

Have you ever had an operation or serious illness? **Yes** **No**

If YES, please explain ____________________

Are you taking any medications or drugs? (Either prescription or non-prescription) **Yes** **No**

If YES, please list____________________

Have you ever had an allergic or adverse reaction to any drug or medication? **Yes** **No**

If YES, please list____________________

Have you taken any prescription medications in the past that you are no longer taking? **Yes** **No**

If YES, please explain ____________________

Have you ever had any abnormal bleeding associated with previous extractions, surgery or trauma? **Yes** **No**

If YES, please explain ____________________

Are you taking any blood thinners?	**Yes**	**No**	Do you have chest pain upon exertion?	**Yes**	**No**
Do you require extra pillows when you sleep?	**Yes**	**No**	Are you short of breath after exercise?	**Yes**	**No**
Does your mouth frequently become dry?	**Yes**	**No**	Do your ankles swell?	**Yes**	**No**
Have you ever taken Bisphosphonates (bone builders)?	**Yes**	**No**			

Do any family members have diabetes? **Yes** **No**

If YES, please explain ____________________

Do you smoke? **Yes** **No** If YES, how much? ____________________

Do you consume alcohol? **Yes** **No** If YES, how much? ____________________

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Heart Murmur	**Yes**	**No**	Chemotherapy	**Yes**	**No**	Diabetes	**Yes**	**No**
Congenital Heart Lesions	**Yes**	**No**	Sinus Trouble	**Yes**	**No**	Emphysema	**Yes**	**No**
Angina Pectoris	**Yes**	**No**	Bruise Easily	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Heart Pacemaker	**Yes**	**No**	Fainting or Dizzy Spells	**Yes**	**No**	Arthritis	**Yes**	**No**
Stroke	**Yes**	**No**	AIDS/HIV	**Yes**	**No**	Cold Sores	**Yes**	**No**
Anemia	**Yes**	**No**	Thyroid Trouble	**Yes**	**No**	Pain in Jaw Joint	**Yes**	**No**
Hepatitis	**Yes**	**No**	Rheumatic Fever	**Yes**	**No**	Radiation Therapy	**Yes**	**No**
Asthma	**Yes**	**No**	Heart Disease/ Heart Attack	**Yes**	**No**	Mouth Ulcers	**Yes**	**No**
Chronic Cough	**Yes**	**No**	Artificial Heart Valves	**Yes**	**No**	Epilepsy or Seizures	**Yes**	**No**
Tumors	**Yes**	**No**	Heart Surgery	**Yes**	**No**	Mononucleosis	**Yes**	**No**
Liver or Kidney Trouble	**Yes**	**No**	High or Low Blood Pressure	**Yes**	**No**	Stomach Ulcers	**Yes**	**No**

Is there anything about your general health that your dentist should know? ____________________

INSURANCE/AGREEMENT *(Select one of the three choices by circling the corresponding number)*

1. I have no dental insurance. I elect to pay cash___, check____, Mastercard___, Visa____.

2. I elect to pay in full at time of treatment and be responsible for filing my own insurance.

3. I elect to pay my deductible and out-of-pocket portion at time of treatment. Your office will file my insurance.

If you chose (3) for your insurance billing, please read and sign the following statement before we agree to accept assignment directly from your insurance company.

I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR THE PAYMENT OF ALL TREATMENT FEES ON MY ACCOUNT. IF MY INSURANCE COMPANY FAILS TO MAKE PAYMENT WITHIN 60 DAYS, I WILL BE RESPONSIBLE FOR THE FULL AMOUNT OWED TO DR. SOUTHARD

Signature of Responsible Party____________________ Office Manager____________________

Note: Accounts over 90 days will be turned over for collection as provided for by the law of this state.